

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17956

CERTIFICATE OF DEATH

17953

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Chestnut	
3. NAME OF DECEASED (Type or print) Rosa		4. DATE OF DEATH Month December Day 16 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 81 yrs.
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pierce Bennett		14. MOTHER'S MAIDEN NAME Josephine Lopes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-9250	
17. INFORMANT Grover C. Bennett, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 592X IMMEDIATE CAUSE (a) Uremia DUE TO (b) chronic nephritis DUE TO (c) Diabetes mellitus - degenerative heart disease		INTERVAL BETWEEN ONSET AND DEATH 3-?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - degenerative heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1966 to 12/16, 1966 , that (I) (we) lost saw the deceased alive on 12/16, 1966 , and that death occurred at 11:50 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Earl Beardsley		22b. DATE SIGNED 12/17/66	
22c. PHYSICIAN'S NAME (Type) EARL BEARDSLEY		22d. ADDRESS 207 MARYLAND AVE. SALISBURY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-66	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Charles H. Grogan - Delmar, Del.		25a. REC'D BY REGISTRAR DEC 21 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1955

Wisconsin

Bellevue

Penitentiary General Hospital

Chicago

1955-1956

Chicago

Chicago

1955-1956

Chicago

Chicago

1955

Penitentiary of Illinois

Chicago

Chicago

Chicago

1955-1956

Chicago

Chicago

1955-1956

Chicago

Chicago

17957

CERTIFICATE OF DEATH

17954

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 304 Hammond St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert GILBERT Bacon First Middle Last 4. DATE OF DEATH December 7 19 66 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 26, 1960 9. AGE (In years lost birthday) 6 yrs. IF UNDER 1 YEAR Months Days Hours Min. 4 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY -- 11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert D. Bacon 14. MOTHER'S MAIDEN NAME Helen Lee Pack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no -- 16. SOCIAL SECURITY NO. -- 17. INFORMANT Mr. & Mrs. Robert Bacon (Parents) 304 Hammond Street, Salisbury, Maryland Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2002 IMMEDIATE CAUSE (a) Multiple widespread Metastasis DUE TO (b) Malignant Lymphoma DUE TO (c) 8 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) N/A		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/14, 1966 , to 12/7, 1966 , that (I) (we) lost saw the deceased alive on 12/7/66 , and that death occurred at 10:35 PM , from causes and on the date stated above.			
22a. SIGNATURE D. G. Anderson 22c. PHYSICIAN'S NAME (Type) Dr. D. G. Anderson		22b. DATE SIGNED 12/7/66 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 10, 1966 23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery 23d. LOCATION (City or Town) (County) (State) Mardela, Maryland		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND 25a. REC'D BY REGISTRAR DEC 12 1966 25b. REGISTRAR'S SIGNATURE R Charles Judge	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 23.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS N. PHILA AVE			
3. NAME OF DECEASED (Type or print) John Calvin Baker				4. DATE OF DEATH Month December Day 18 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 9 1922	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 19 Min.		11. BIRTHPLACE (County & State, or foreign country) OCEAN CITY MD U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.			
13. FATHER'S NAME SAMUEL BAKER				14. MOTHER'S MAIDEN NAME MILDRED POWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-8564		17. INFORMANT MRS J.C. BAKER Address OCEAN CITY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Unanalyzed carcinomatous DUE TO Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Months (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11.9 , 19 66 to 12.18 , 19 66 , that (I) (we) last saw the deceased alive on 12.18 19 66 and that death occurred at 9:45 M, from causes on and on the date stated above.							
22a. SIGNATURE H. H. Briele				22b. DATE SIGNED 12.17.66		22c. PHYSICIAN'S NAME (Type) H. H. Briele	
22d. ADDRESS Medical Center, Salisbury, Md				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/21/66		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BELLEVILLE MD	
24. FUNERAL DIRECTOR Amos A. Burdette Berlin Md				25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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Salisbury

Peninsula General Hospital

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN b. since 11/8/66			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital				d. STREET ADDRESS -			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Raymond Benton				4. DATE OF DEATH Month Day Year December 3 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1892	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eddie Benton				14. MOTHER'S MAIDEN NAME Etta Tawes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no -		16. SOCIAL SECURITY NO. 220-32-0897		17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md. Address +			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 002.1						INTERVAL BETWEEN ONSET AND DEATH 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Oct. 8 , 1966, to Dec. 3 , 1966, that the (we) last saw the deceased alive on Dec. 3 , 1966, and that death occurred at 3:35 PM , from causes and on the date stated above.							
22a. SIGNATURE E. P. Ritchings				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 5, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.				22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 12-6-66		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City or Town) (County) (State) DEAL ISLAND SM MD	
24. FUNERAL DIRECTOR Leroy Webster				25a. REC'D BY REGISTRAR Princess Anne		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17962

CERTIFICATE OF DEATH

17958

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1b 12-10-66	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 835 S. Division St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roscoe Lee Bounds		4. DATE OF DEATH Month December Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1903
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 11 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (County & State, or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Thomas Bounds		14. MOTHER'S MAIDEN NAME Lizzie Bell Malone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-18-2506	
17. INFORMANT Mr. Chester R. Bounds (Brother) Address Route #2, Box 55, Berlin, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO instant (b) bronchogenic Ca DUE TO ? (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 , 19 66 to 12/15 , 19 66 that (I) (we) last saw the deceased alive on 12/15/66 , and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Norbret Fleisig		22b. DATE SIGNED 12/16/66	
22c. PHYSICIAN'S NAME (Type) Dr. Norbret Fleisig		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 18, 1966	
23c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		23d. LOCATION (City or Town) (County) (State) Siloam, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE DEC 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13258

13258

Wichita

Salisbury

Penitentiary General Hospital

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17962

CERTIFICATE OF DEATH

17959

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela			
c. LENGTH OF STAY IN 1b 67 yrs				d. STREET ADDRESS -----			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM ACKWORTH BOUNDS				4. DATE OF DEATH Dec. 28 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1899	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (County & State, or foreign country) Mardela, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas R. Bounds				14. MOTHER'S MAIDEN NAME Annie Bounds			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 212-16-7898		17. INFORMANT Clara Bounds, Mardela, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/21, 1966 to 12/28, 1966 , that (I) (was) last saw the deceased alive on 19 , and that death occurred at 12/29/66 M, from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Hughes M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/29/66	
22c. PHYSICIAN'S NAME (Type) Dr. Richard Hughes				22d. ADDRESS Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-31-66		23c. NAME OF CEMETERY OR CREMATORY Mardela		23d. LOCATION (City, town or county) (State) Mardela, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles H. Spauld - Wilmar, Del.				25a. REC'D BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE John D. Jones	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17963

CERTIFICATE OF DEATH

17960

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 6 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pringhill Sanitarium				d. STREET ADDRESS Camden Ave., Ext.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRTLE Middle GORDY Last BRIELE				4. DATE OF DEATH Month 12 Day 5 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1879		9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alison W. Gordy				14. MOTHER'S MAIDEN NAME Alena Knowles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Henry A. Briele, See Sec #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebral Arteriosclerosis And DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct. , 19 66 to Dec 5 , 19 66 , that (I) (we) last saw the deceased alive on Dec 4 , 19 66 , and that death occurred at 1204 M, from causes on and on the date stated above.							
22a. SIGNATURE Thomas C. Hill Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-5-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-1966		23c. NAME OF CEMETERY OR CREMATORY Quantico Meth, Ch.		23d. LOCATION (City or Town) (County) (State) Quantico, Maryland	
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland				25a. REC'D BY REGISTRAR DATE DEC 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17961

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>221</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>		d. STREET ADDRESS <u>409 Lake St.</u>	
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>BRIGGS</u> Last <u>BRIGGS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1917</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>25</u> Hours <u>19</u>	
11. BIRTHPLACE (State or foreign country) <u>Margateville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Jessie PARKER</u>		14. MOTHER'S MAIDEN NAME <u>Lillian CHAPMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-16-9024</u>	
17. INFORMANT <u>Clarence Parker</u>		Address <u>664 N.W. 56th Miami, Fla.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>981X</u> IMMEDIATE CAUSE (a) <u>Bullet wound of heart</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot during argument</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:05</u> <u>p.m.</u> <u>12-25-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>December 27, 1966</u>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Margateville</u>	23d. LOCATION (City or town) (County) (State) <u>Margateville</u> <u>North</u> <u>N.C.</u>
24. FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17965

CERTIFICATE OF DEATH

17962

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Adm 12/8/66</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANKLIN</u> Last <u>BRITTINGHAM</u>			4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1896</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsville, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Elijah J. W. Brittingham</u>		
14. MOTHER'S MAIDEN NAME <u>Minerva Parker</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>218-48-6197</u>			17. INFORMANT <u>Mrs. Lillie M. Brittingham (Wife)</u> <u>Pittsville, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & Pulmonary embolism</u> 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis & Emphysema</u> (c) <u>5 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>12/8/66</u>	
20f. (City or town) <u>Pittsville</u>		20g. (County) <u>Maryland</u>		20h. (State) <u>Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/8/66</u> to <u>12/11/66</u> , that (I) (we) last saw the deceased alive on <u>12/11/66</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED <u>Dec. 12/1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Oswald J. Burton</u>			22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pittsville Cemetery</u>	
23d. LOCATION (City, town or county) <u>Pittsville, Maryland</u>		23e. (State) <u>Maryland</u>		23f. REC'D BY REGISTRAR <u>DEC 14 1966</u>	
23g. REGISTRAR'S SIGNATURE <u>[Signature]</u>		23h. REGISTRAR'S SIGNATURE <u>[Signature]</u>		23i. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THE", "AND", "OF" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17966						17963					
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Gay & Parsons St. John B. Parsons Home for Aged e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
3. NAME OF DECEASED (Type or print) First Frances Middle (none) Last Bruce						4. DATE OF DEATH Month December Day 12 Year 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Bruce						14. MOTHER'S MAIDEN NAME Ida Mitchell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)						16. SOCIAL SECURITY NO. no					
17. INFORMANT Records: John B. Parsons Home for Aged						Address Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5da											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) (this hospital) attended the deceased from 12-7 , 19 66 to 12-12 , 19 66 that (I) (we) last saw the deceased alive on 12-12 , 19 66 , and that death occurred at 12:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Wallace M.D.						22b. DATE SIGNED 12-12-66					
22c. PHYSICIAN'S NAME (Type) Thomas F. Wallace						22d. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 12-14-1966		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory				23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace ADDRESS Salisbury, Md.						25a. REC'D BY REGISTRAR DEC 16 1966 DATE DEC 16 1966					
25b. REGISTRAR'S SIGNATURE Charles Judge											

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CENTINITY OF DEATH

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17967

CERTIFICATE OF DEATH

17964

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galestown (Rural) 19.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.D.#3 Seaford, Del.	
3. NAME OF DECEASED (Type of print) Robert First Middle ANTHONY Last Capp		4. DATE OF DEATH December 31 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21/1899
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker- Retired	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME (Unk)		14. MOTHER'S MAIDEN NAME (Unk)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 100-01-8062	
17. INFORMANT Mrs. Estelle Hoffman Capp (Wife)		Address (Same as Item #2 above) Ph-301-883-3479	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Dissecting aortic aneurysm DUE TO (b) Infarcted sigmoid colon DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12/31 , 19 66 , that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 3:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Richard E. Hughes		22b. DATE SIGNED 1/1/67	
22c. PHYSICIAN'S NAME (Typed) Dr. Richard E. Hughes		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 4/1966	23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Cemetery	23d. LOCATION (City or Town) _____ (County) _____ (State) Long Island, New York
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 10 Film G383 12/14/66 mh

17968

CERTIFICATE OF DEATH

17965

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS R.D.#4, Ocean City Road			
3. NAME OF DECEASED (Type or print) Leo ARTHUR COCHRAN				4. DATE OF DEATH December 1 1966 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1900		9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & operator Retired Maintenance Serv.			10b. KIND OF BUSINESS OR INDUSTRY Meat Co.		11. BIRTHPLACE (County & State, or foreign country) Harford County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Cochran				14. MOTHER'S MAIDEN NAME Mary Bradley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-7394		17. INFORMANT Mrs. Mary A. Cochran (Wife) R.D.#4, Ocean City Road, Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.0							INTERVAL BETWEEN ONSET AND DEATH Less than 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 66 , to 12-1 , 19 66 , that (I) (we) last saw the deceased alive on 12-1 , 19 66 , and that death occurred at 12:00 AM , from causes and on the date stated above.							
22a. SIGNATURE W. R. Ellis, Jr.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-1-66	
22c. PHYSICIAN'S NAME (Type) Dr. W. R. Ellis, Jr.				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Long Green, Harford, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13882

CENTRAL OF ILL.

13882

Wisconsin

Bellevue

Bellevue General Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17969

CERTIFICATE OF DEATH

17966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin d. STREET ADDRESS R.D. #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph CLINTON DAWSON		4. DATE OF DEATH Month Day Year December 4 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 1 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver - trucker		10b. KIND OF BUSINESS OR INDUSTRY Lewis, Delaware	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Brooks Dawson		14. MOTHER'S MAIDEN NAME Martha Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 222-09-1321	
17. INFORMANT Mrs. Doris Helen Dawson (wife) R.D. #3, Berlin, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO (b) Coronary Atherosclerosis DUE TO (c) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 66 , to 12/4 , 19 66 , that (I) (we) lost saw the deceased alive on 12/4 , 19 66 , and that death occurred on 12/4 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED Dec. 4 1966	
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 8, 1966	
23c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery		23d. LOCATION (City or Town) (County) (State) Wicomico, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE DEC 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13880

DEPARTMENT OF STATE

17589

Alomino

Salisbury

Peninsula General Board

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17970

CERTIFICATE OF DEATH

17967

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb Life Time	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 19.2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Celeste			First Middle Last Dennis	4. DATE OF DEATH Dec. 23, 1966			Month Day Year
5. SEX Female	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/1899		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Princess Anne, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Anothey James				14. MOTHER'S MAIDEN NAME Laura Waters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Creston Dennis, Princess Anne, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis (b) generalized arterio sclerosis (c) previous cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) previous cerebral thrombosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1966 , to 12/23, 1966 that (I) (we) last saw the deceased alive on 12/23, 1966 , and that death occurred at 2:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE Charles Judge				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/23/66	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/66		23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) (State) Princess Anne, Maryland	
24. FUNERAL DIRECTOR William H. James Jr Princess Anne, Md				25a. REC'D BY REGISTRAR DEC 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

M

17971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17968

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) First HOWARD Middle GRAY Last DENNIS		4. DATE OF DEATH Month 12-26-66 Day 19 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cripple		10b. KIND OF BUSINESS OR INDUSTRY Did not Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson Lee Dennis		14. MOTHER'S MAIDEN NAME Annie Jane Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX		16. SOCIAL SECURITY NO. XX	
17. INFORMANT Viola Dennis Pittsville, Md. RD 1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Ischemic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED December 27, 1966	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/66	
23c. NAME OF CEMETERY OR CREMATORY Pittsville		23d. LOCATION (City or Town) (County) (State) Pittsville	
24. FUNERAL DIRECTOR Watson & Whaley, Selbyville, Del.		25. REC'D BY REGISTRAR JAN 3 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit and in any event within 72 hours after death. Health or its designated agent, prior to burial, cremation, or removal.

15062

NO. 15062

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15062

John Brown

John Brown

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17969

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 775 East Road	
3. NAME OF DECEASED (Type or print) First HOWARD Middle DILLARD Last DILLARD		4. DATE OF DEATH Month 12-30-66 Day 19 Year 1933	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1933
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME Gus Dillard		14. MOTHER'S MAIDEN NAME Bulah Dillard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-1903	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Bullet wound of heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during dice game argument.	
20c. TIME OF INJURY Month, Day, Year Hour 9:50 p.m. 12-30-66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED January 3, 1967	
EXAMINER'S NAME (Type) 109 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/5/1967	23c. NAME OF CEMETERY OR CREMATORY Green Acres	23d. LOCATION (City or Town) (County) (State) Salisbury Md.
24. FUNERAL DIRECTOR Clinton Stewart, Salisbury, Md.		25a. REC'D BY REGISTRAR JAN 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 14 Film G384 12/22/66 mh

17973

CERTIFICATE OF DEATH

17970

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		14.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ann DODSON		4. DATE OF DEATH Month Day Year December 8 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/88 1891
9. AGE (In years last birthday) 75yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles E. Davis		14. MOTHER'S MAIDEN NAME Angeline Coleman Cobourn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Willard Dodson - Worton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3-4 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 15, 1966 , to December 8, 1966 , that (I) (we) last saw the deceased alive on December 8 1966 , and that death occurred at 5:30PM , from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 12/19/66	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell		22d. ADDRESS Deer's Head State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/66	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR DATE DEC 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17974

CERTIFICATE OF DEATH

17971

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN d. STREET ADDRESS RT ST. MARTINS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ollie Y. DONAWAY First Middle Last 4. DATE OF DEATH DECEMBER 16 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MAR. 15, 1890 9. AGE (In years last birthday) 76 Yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. BIRTHPLACE (County & State, or foreign country) BERLIN, MD 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN G. DONAWAY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or of unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 2-20-34-9418 17. INFORMANT MISS. GERTRUDE DONAWAY Address RT. 1, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Arteriosclerotic heart disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suprapubic prostatectomy 12/12/66 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 66 , to 12/16 , 19 66 , that (I) (we) last saw the deceased alive on 12/16 , 19 66 , and that death occurred at 9:45 M, from causes and on the date stated above.			
22a. SIGNATURE Walter D. Canley 22c. PHYSICIAN'S NAME (Type) Walter D. Canley		22b. DATE SIGNED 12/16/66 22d. ADDRESS RT. 1, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/20/66 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN 23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD		24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md 25a. REC'D BY REGISTRAR DEC 21 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

Wisconsin

Salisbury

Peninsula General Hospital

17871

DEPARTMENT OF HEALTH

17871

17975

CERTIFICATE OF DEATH

17972

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 22.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 912 Johnson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CLARRISA (CLARISSA) ELLEN Elliott			4. DATE OF DEATH Month Day Year December 18 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1898		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William B. Elliott			14. MOTHER'S MAIDEN NAME Victoria Phippin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-10-9641	17. INFORMANT Address Mrs. Margaret Louise Wagner 920 Brown Street, Salisbury, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 Chronic renal insufficiency DUE TO (b) Chronic pyelonephritis DUE TO (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 12-13 , 19 66 , to 12-18 , 19 66 that (I) (we) last saw the deceased alive on 12-17 19 66 , and that death occurred at 1:30 M, from causes and on the date stated above.					
22a. SIGNATURE Hubert R. White, Jr.			22b. DATE SIGNED Dec. 18 / 1966		
22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr.			22d. ADDRESS Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 21, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DATE DEC 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17976

CERTIFICATE OF DEATH

17973

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Middle Last MAY 4. DATE OF DEATH December 26 1966 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 27, 1895 9. AGE (In years lost birthday) 71 yrs. IF UNDER 1 YEAR Months Days Hours Min. 0 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Worcester County, Md. 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Thomas Livingston 14. MOTHER'S MAIDEN NAME Sarah Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 215-07-3638A 17. INFORMANT Mr. Preston L. Williams (Son) Address 612 Liberty Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Arterial Hemorrhage DUE TO (b) Arteriosclerotic Hypertensive Cerebro DUE TO (c) Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street/office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29/66 , to 12/26/66 , that (I) (we) last saw the deceased alive on 12/24/66 , and that death occurred at 9 a M, from causes and on the date stated above.		22a. SIGNATURE Dr. J. J. Burton 22c. PHYSICIAN'S NAME (Type) Dr. J. J. Burton 22b. DATE SIGNED Dec. 26/1966 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 28, 1966 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery 23d. LOCATION (City or Town) (County) (State) Fruitland, Maryland		25a. REC'D BY REGISTRAR DEC 29 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND ADDRESS			

17328

17328

Wisconsin

Bellevue

Peninsula General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17977 CERTIFICATE OF DEATH 17974									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 11-28-66		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury 221			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 612 Truitt Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last ENNIS			4. DATE OF DEATH Month December Day 8 Year 1966						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1921		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 5 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator			10b. KIND OF BUSINESS OR INDUSTRY Bottling Company		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Roy W. Ennis					14. MOTHER'S MAIDEN NAME Ella Fields				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-03-8128		17. INFORMANT Mrs. Frances R. Ennis (Wife) 612 Truitt St., Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH carcinoma	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 66 , to 12-8 , 19 66 , that (I) (we) last saw the deceased alive on 12-7 , 19 66 , and that death occurred at 2:45 M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. Wilbur R. Ellis, Jr.					22b. DATE SIGNED Dec. 12-8/1966		22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R. Ellis, Jr.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Dec. 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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17978

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 5 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 804 Alvin Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) NORMA LABAR		4. DATE OF DEATH Month 12 Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb, 14, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) yrs. 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Newark, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses D. LaBar		14. MOTHER'S MAIDEN NAME Mary Elliott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 156-22-8530	
17. INFORMANT Mrs. Edward Coulston		Address See Sec. 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 5 19 66 , and that death occurred at 10:05 A M, from causes and on the date stated above.			
22a. SIGNATURE William D. Gray		22b. DATE SIGNED 12-6-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. D. Gray		22d. ADDRESS 334 Camden Ave., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-8-1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DEC 8 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

13032

CERTIFICATE OF DEATH

13032

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
PLACE OF BIRTH		DATE OF BIRTH	
OCCUPATION		EDUCATION	
MARRIAGE		RELIGION	
CAUSE OF DEATH		PLACE OF DEATH	
DATE OF INTERMENT		PLACE OF INTERMENT	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
OFFICE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	

17979

CERTIFICATE OF DEATH

17976

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rehoboth		19.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Box 181 Marion Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Mae Last Fitchett		4. DATE OF DEATH Month December Day 5 Year 1966	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1917
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Phila Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Fitchett		14. MOTHER'S MAIDEN NAME Grace Handy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lula Mae Green		Address Las. Calif.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) 332X DUE TO (c) 24hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 1 , 19 66 to Dec. 5 , 19 66 , that (I) (we) last saw the deceased alive on Dec. 4 , 19 66 , and that death occurred at 5:00 M, from causes and on the date stated above.			
22a. SIGNATURE David J. Williams		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 8 1966	23c. NAME OF CEMETERY OR CREMATORY Marumsco	23d. LOCATION (City or Town) (County) (State) Rehoboth Md
24. FUNERAL DIRECTOR Anthony E. Ward		25a. REC'D BY REGISTRAR DATE DEC 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17980					17977				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. CDUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>221</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>220 Hazel Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FOSTER</u>			4. DATE OF DEATH Month Day Year <u>December 24 1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8:54 P.M.</u> <u>Dec. 24, 1966</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>0</u> yrs. Months Days Hours Min. <u>1 36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph (NMI) Foster</u>					14. MOTHER'S MAIDEN NAME <u>Lillian Rubin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Mr. Joseph Foster 220 Hazel Avenue, Salisbury, Maryland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 36 min</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/24, 1966</u> , to <u>10/24, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/24 1966</u> , and that death occurred at <u>10:30</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>D. B. Anderson</u>					22b. DATE SIGNED <u>Dec. 27/1966</u>			22c. PHYSICIAN'S NAME (Type) <u>Dr. Daniel G. Anderson</u>	
22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Dec. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Israel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17981

CERTIFICATE OF DEATH

17978

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville d. STREET ADDRESS 221 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IVZ L. GAINES		4. DATE OF DEATH Month December Day 25 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/23/1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 61 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herman Brown		14. MOTHER'S MAIDEN NAME Martha Garnier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 22-14-9875	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Possible Occlusion DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease 3 years (c) Angina 3 years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19 Dec 25 , 19 66 that (I) (we) last saw the deceased alive on Dec 17 , 19 66 and that death occurred at 1:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Herbert Sembly		22b. DATE SIGNED 12/25/66	
22c. PHYSICIAN NAME (Type) G. Herbert Sembly		22d. ADDRESS Salisbury, Md. 21801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/66	23c. NAME OF CEMETERY OR CREMATORY Jesterville Cem.	23d. LOCATION (City or Town) (County) (State) Jesterville Md.
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DEC 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1978

MINISTRY OF HEALTH

1978

Alameda

Alameda

Alameda General Hospital

1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17982

CERTIFICATE OF DEATH

17973

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2317 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mina Middle Elmyra Last GARDNER		4. DATE OF DEATH Month December Day 8 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17 - 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17	
11. BIRTHPLACE (County & State, or foreign country) CHESTER MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES H. BENTON		14. MOTHER'S MAIDEN NAME MARY E. JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-52-8798	
17. INFORMANT BENTON GARDNER		Address STEVENSVILLE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO with myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ lost. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 4 , 19 60 , to December 8 , 19 66 , that (I) (we) last saw the deceased alive on December 8 , 19 66 , and that death occurred at 2:09AM , from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 12/8/66	
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Maldve		22d. ADDRESS Deer's Head State Hospital Salisbury Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 10	
23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City or Town) (County) (State) STEVENSVILLE MD.	
24. FUNERAL DIRECTOR Edgar L. Lane		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Church Hill, Md.		25b. REGISTRAR'S SIGNATURE DEC 12 1966	

S8251

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17983

CERTIFICATE OF DEATH

17980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 23.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY d. STREET ADDRESS GOLF COURSE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EUGENE GIGNAC				4. DATE OF DEATH Month Day Year DECEMBER 15 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24 1899	
9. AGE (In years lost birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSMISSION SUP.		10b. KIND OF BUSINESS OR INDUSTRY GENERAL MOTORS		11. BIRTHPLACE (County & State, or foreign country) DETROIT MICH	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS GIGNAC			
14. MOTHER'S MAIDEN NAME ADELAIDE GAGNE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 364-03-2778				17. INFORMANT Address MRS. EUGENE GIGNAC OCEAN CITY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Acute leukemia & pneumonia DUE TO (c) stating the underlying cause lost. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Keep seen throat (A leg)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 4:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Richard E. Hughes				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/15/66	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/19/66		23c. NAME OF CEMETERY OR CREMATORY ROSLYN		23d. LOCATION (City or Town) (County) (State) DETROIT MICH	
24. FUNERAL DIRECTOR Anna A. Burbage				ADDRESS BERLIN MD		25a. REC'D BY REGISTRAR DATE DEC 19 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1308B

STATE OF TEXAS

13383

Wichita

Salisbury

Penitentiary Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17984

CERTIFICATE OF DEATH

17981

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) John B. Parsons Home		d. STREET ADDRESS W. Isabella St.	
3. NAME OF DECEASED (Type or print) First IDA Middle ELEANOR Last GRAVENOR		4. DATE OF DEATH Month December Day 7 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1872
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 5 Days 26 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James N. P. Holloway		14. MOTHER'S MAIDEN NAME Ellen Cathell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT -John B. Parsons Home, Salisbury, Maryland		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " Insufficiency " DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 66 to 12/7 , 19 66 , that (II) (we) last saw the deceased alive on 12/7 , 19 66 , and that death occurred at 7:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. William B. Smith		22b. DATE SIGNED Dec. 9 / 1966	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 12 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

17351

17351



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17985

CERTIFICATE OF DEATH

17982

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 25 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ocean City Rd.,		e. STREET ADDRESS Ocean City Rd.,	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MILTON Last HARRINGTON		4. DATE OF DEATH Month 12 Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1890
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 12 Days 8	IF UNDER 24 HRS. Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Circulation		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (County & State, or foreign country) Queen Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Harrington		14. MOTHER'S MAIDEN NAME Susan Stafford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. I Marine		16. SOCIAL SECURITY NO. 214-10-8344	
17. INFORMANT Mrs. Pauline W. Harrington		Address See Sec. 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia DUE TO 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22 , 19 63 , to 12/8 , 19 66 , that (I) (we) last saw the deceased alive on 12/8 , 19 66 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE John T. Bulkeley M.D.		22b. DATE SIGNED 12-9-1966	
22c. PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-10-1966	
23c. NAME OF CEMETERY OR CREMATORY Allen, Cemetery		23d. LOCATION (City or Town) (County) (State) Allen, Maryland	
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE DEC 13 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6834

32051

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17986					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					17983				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>			c. LENGTH OF STAY IN lb <u>all Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>			22.1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 50</u>					d. STREET ADDRESS <u>Route 50</u>									
3. NAME OF DECEASED (Type or print) First <u>GEORGIA</u> Middle <u>SMALL</u> Last <u>HARRIS</u>					4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1966</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1916</u>		9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>George SAVAGE</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN Blanche SMALL</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>State Police</u>				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					22. DATE SIGNED <u>December 22, 1966</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>			23d. LOCATION (City or Town) (County) (State) <u>Mardela Wico. Md.</u>							
24. FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

M

15886

11023

AT WYOMING TERRITORY DEPT OF STATE

[Faint, mostly illegible text and markings covering the page]

17987

CERTIFICATE OF DEATH

17984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 46.3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY Sussex c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRIDGEVILLE d. STREET ADDRESS Rt # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAFAYETTE First Middle Last HASTINGS		4. DATE OF DEATH Month Day Year December 23, 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RT FARMER		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wm Clayton Hastings	
14. MOTHER'S MAIDEN NAME Mary Rigger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 7		17. INFORMANT Alvin Hastings - Bridgeville Del Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) #6			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-21-66 , 19 to 12-23 , 1966, that (I) (we) last saw the deceased alive on 12-23 , 1966, and that death occurred at 2:27 M, from causes and on the date stated above.			
22a. SIGNATURE Joseph C. Fitzgerald		22b. DATE SIGNED 12-24-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-26-66	Old Yellow	Seaford Del
24. FUNERAL DIRECTOR Charles W. Garrel - Seaford, Del		25a. REC'D BY REGISTRAR DEC 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1594

STATE OF DEATH

17837

Widowed

Single

Penland's General Hospital

17988

CERTIFICATE OF DEATH

17985

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City 23.2 d. STREET ADDRESS R.F.D. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ROSE Last HEINER		4. DATE OF DEATH Month DECEMBER Day 3 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1879 9. AGE (In years last birthday) yrs. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Cloney		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-9705 17. INFORMANT Martin B. Heiner, Pocomoke City, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Probable Pulmonary Embolism (b) Coronary Fibrillation DUE TO years (c) ASH D		INTERVAL BETWEEN ONSET AND DEATH 2-3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 19 66 to 12-3, 19 66 that (I) (we) last saw the deceased alive on Dec 2, 19 66 and that death occurred at 7:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE David Rafat		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-5-1966	23c. NAME OF CEMETERY OR CREMATORY First Baptist	23d. LOCATION (City or Town) (County) (State) Pocomoke City, Maryland
24. FUNERAL DIRECTOR Robert H. Watson Robert H. Watson		25a. REC'D BY REGISTRAR DEC 8 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAINTAIN STATE DEPARTMENT OF HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. GOVERNMENT PRINTING OFFICE: 1965

1738

1738

Wisconsin

Madison

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

Pennington General Hospital

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Pennington General Hospital

Pennington General Hospital

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

17989

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17986

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> 23.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Washington St.</u>	
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>B.</u> Last <u>HOLLAND</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. HOLLAND</u>		14. MOTHER'S MAIDEN NAME <u>MARY ENNIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. NANCY DEDDEN</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured right elbow</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps at home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9</u> xxx <u>11-27-66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>own home</u>	20f. (City or town) (County) (State) <u>Berlin, Worcester, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>December 6, 1966</u>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		Address (Street, city, town, or county)	
23a. 8. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR. MD</u>
24. FUNERAL DIRECTOR <u>Burbage Funeral Home, Berlin, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

1380

9333

John R. [unclear]

17990

CERTIFICATE OF DEATH

17987

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 148 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve 22.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle ALFONZO Last HORNER				4. DATE OF DEATH Month 12 Day 21 Year 19 66			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1878 88		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levin Horner				14. MOTHER'S MAIDEN NAME Amanda Lewis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 2 12-16-7097A		17. INFORMANT Clarence Horner, Tytockin, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 5-10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (1) Arteriosclerotic cardiovascular disease (yrs.); (2) Cerebral (6mo) thrombosis, right, with hemiplegia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 26, 19 66 , to Dec. 21, 19 66 , that (I) (we) last saw the deceased alive on Dec. 21, 19 66 , and that death occurred at 3:10 PM , from causes and on the date stated above.							
22a. SIGNATURE Charles H. Winnacott				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/21/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.				22d. ADDRESS Deer's Head State Hosp., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/66		23c. NAME OF CEMETERY OR CREMATORY Bivalve Cem.		23d. LOCATION (City or Town) (County) (State) Bivalve, Md.	
24. FUNERAL DIRECTOR Charles H. Winnacott				ADDRESS Bivalve, Md.		25a. REC'D BY REGISTRAR DEC 21 1966 DATE	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15321

0025-5

17991

CERTIFICATE OF DEATH

17988

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Quantico Rd.,	
3. NAME OF DECEASED (Type or print) First Medford Middle Hanna Last Humphreys		4. DATE OF DEATH Month December Day 23 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming, Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland Wicomico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephus Humphreys		14. MOTHER'S MAIDEN NAME Harriet Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-8057 A	
17. INFORMANT Mrs. G. Wilson Wharton, See Sec. 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Coronary Thrombosis DUE TO Arteriosclerotic Cardiovascular Dis last. 4/20.1			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 yrs. 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 63 to 12/23 , 19 66 , that (I) (we) last saw the deceased alive on 12/23 , 19 66 , and that death occurred at 11:45 M, from causes and on the date stated above.			
22a. SIGNATURE Rufus S. G. Ardner, Jr.		22b. DATE SIGNED 12/23/66	
22c. PHYSICIAN'S NAME (Type) RUFUS S. G. ARDNER, JR.		22d. ADDRESS MEDICAL CENTER, SALISBURY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-27-1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MINISTRE DE LA JUSTICE

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17992

CERTIFICATE OF DEATH

17989

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb 86 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 346 Carey Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clayton William JONES, JR.				4. DATE OF DEATH Month December Day 15 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1916	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 4 Days 11 Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Plumbing		13. FATHER'S NAME Clayton William Jones, Sr.	
13. FATHER'S NAME Clayton William Jones, Sr.				14. MOTHER'S MAIDEN NAME Beulah K. White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 716-01-7181		17. INFORMANT Mrs. Mattie Elizabeth Jones (Wife) 346 Carey Avenue, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 193.0 IMMEDIATE CAUSE (a) Metastatic Ca Brain with DUE TO (b) Left Hemiplegia (Previous stroke unknown) DUE TO (c) Convulsions secondary to (a)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs (?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) N/a			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/a		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 20 19 66 , to December 15, 1966 , that (I) (we) last saw the deceased alive on December 15 19 66 , and that death occurred at 6:00AM , from causes and on the date stated above.							
22a. SIGNATURE Dr. C. H. Winnacott				22b. DATE SIGNED 12/15/66		22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott	
22d. ADDRESS Deer's Head State Hospital				22e. LOCATION (City or Town) (County) (State) Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17993

17990

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 170 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS RD.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ida Middle May Last JONES		4. DATE OF DEATH Month December Day 28 Year 19 66	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 09 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Young		14. MOTHER'S MAIDEN NAME Annie Chester	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-3833	
17. INFORMANT James H. Jones, Rhodesdale, Maryland, RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli (Terminal) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Terminal 10 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 11 , 19 66 , to December 28 19 66 , that (I) (we) last saw the deceased alive on December 28 19 66 , and that death occurred at 12:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. A. C. Mitchell		22b. DATE SIGNED 12/28/66	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY Thompsonstown Cemetery		23d. LOCATION (City or Town) (County) (State) Near East New Market, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DEC 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17991

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westover</u> <u>19.2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARLTON</u> Middle <u>H.</u> Last <u>LAMBERTSON</u>				4. DATE OF DEATH Month <u>12</u> -Day <u>3</u> -Year <u>66</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-34</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl Henry Lambertson</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Outten</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-5616</u>		17. INFORMANT Address <u>Mrs Priscilla Lambertson, Westover, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>061X</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Tetanus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>23 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stuck rusty nail in rt. thumb while working in chicken house</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>pm</u> <u>11-10-66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>own farm</u>		20f. (City or town) (County) (State) <u>Westover, Somerset, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				22. DATE SIGNED <u>December 5, 1966</u>			
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-1966</u>		23c. NAME OF CEMETERY OR REMOVAL <u>Salem Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Pocomoke City, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert H. Watson</u> ADDRESS <u>Watson Funeral Home, Pocomoke, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17995						17992					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY WICOMICO			MARYLAND			a. STATE MD.			b. COUNTY WIC.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WETIPQUIN			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WETIPQUIN			d. STREET ADDRESS P.O. 148 QUANTICO, MD. RT. 1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last SAMUEL BRUCE LANKFORD						Month Day Year 12 19 1966					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 2, 1872		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) WIC, MD.		12. CITIZEN OF WHAT COUNTRY? YES		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME ARNOLD LANKFORD						14. MOTHER'S MAIDEN NAME MARY ANN WRIGHT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. 217-30-8307					
17. INFORMANT Address JULIA BORNE, Phila. Pa.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day Indefinite											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan 65 to Dec 66, that (I) (we) last saw the deceased alive on Dec 19 1966 and that death occurred at 3:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE F. A. Parnell M.D.											
22b. DATE SIGNED 29 Dec 66											
22c. PHYSICIAN'S NAME (Type) F. A. Parnell M.D. 52 W. Main St. Stry. Ind.											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF 12/24/66											
23c. NAME OF CEMETERY OR CREMATORY Old Fellows											
23d. LOCATION (City, town or county) (State) Wet. p. quin, MD.											
24. FUNERAL DIRECTOR'S SIGNATURE Booker M. West											
25a. REC'D BY REGISTRAR DATE JAN 3 1967											
25b. REGISTRAR'S SIGNATURE Charles Judge											

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

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17993

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 2 Hrs.				d. STREET ADDRESS 719 Alvin Ave.,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABLE		First CHAUKLEY		Last LEEDS		4. DATE OF DEATH 12 12 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1883		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Milliner		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? US.A.	
13. FATHER'S NAME Chaukley Leeds				14. MOTHER'S MAIDEN NAME Rose Young			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Sally M. Twilley, See Sec. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Fractures 8/61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger Auto - collided & turned							
20c. TIME OF INJURY Month, Day, Year 3:25 p.m. 12-12-66		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 353		20f. (City or town) Patterson (County) Wicomico (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-16-1966		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23. FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR Charles Judge	
24b. REGISTRAR'S SIGNATURE Charles Judge				DATE DEC 19 1966			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman & Baber

17388

17388

Multiple Fractures

5/1/88

Fracture Site - stable - full

Internal bone

11-11-88

32° O 11-11-88

Sub-acute

2/1/88

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17997

CERTIFICATE OF DEATH

17994

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 408 Maryland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MABEL		First JANE		Middle LEWIS		Last		4. DATE OF DEATH Month DECEMBER Day 3 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1894		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt Nurse		10b. KIND OF BUSINESS OR INDUSTRY State Hospital		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elmer Lewis				14. MOTHER'S MAIDEN NAME Bertha Wolfe					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 300-26-4076		17. INFORMANT Dora Cannon, Delmar, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 164X IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Tubercular & suppurative Caval obstructions DUE TO (c) Mediastinal Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased, alive on _____, 19____, and that death occurred at 7:30 M, from causes and on the date stated above.									
22a. SIGNATURE Richard E. Hughes				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/4/66			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-66		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. Park		23d. LOCATION (City or Town) (County) (State) Delmar, Del.			
24. FUNERAL DIRECTOR MARVEL FUNERAL HOME, 1st & GROVE STS.,				25a. REC'D BY REGISTRAR DATE DEC 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1525

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17998

CERTIFICATE OF DEATH

17998

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS West Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Moses		First		Middle LIVINGSTON		Last		4. DATE OF DEATH Month December Day 3 Year 1966	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-06		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bolden Livingston				14. MOTHER'S MAIDEN NAME Nettie Randolph					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 267-18-7137		17. INFORMANT Thomas Livingston West Road Salis Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421/1 Congestive heart failure DUE TO (b) Corotic stenosis & insufficiency DUE TO (c) Unk.								INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from 11/29 , 19 66 , to 12/3 , 19 66 , that (1) was last saw the deceased alive on 12/2 , 19 66 , and that death occurred at 10:15 M, from causes on and on the date stated above.									
22a. SIGNATURE George H. Hendling				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/4/66			
22c. PHYSICIAN'S NAME (Type) George H. Hendling				22d. ADDRESS 1302 Ocean City Rd, Salisbury Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/1966		23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR Clinton F. Stewart Salis Md.				ADDRESS		25a. REC'D BY REGISTRAR DEC 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17003

17003

Historia

Salisbury

Peninsula General Hospital

THE PENINSULA GENERAL HOSPITAL
SALISBURY
HISTORIA
17003

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17999

17996

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 2 WKS.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. STREET ADDRESS MARYLAND				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First F		Middle LUTZ		Lost LUTZ		4. DATE OF DEATH Month DECEMBER	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 31-1898		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY ELECTRICIAN		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AMOS J. LUTZ				14. MOTHER'S MAIDEN NAME JENNIE CHAPMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS HELEN LUTZ - WENONA MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1562 IMMEDIATE CAUSE (a) Metastatic carcinoma to liver DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at 2:57 M, from causes on and on the date stated above.									
22a. SIGNATURE Richard E. Hughes				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12/9/66	
22c. PHYSICIAN'S NAME (Type) Richard E. Hughes				22d. ADDRESS Salisbury - MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 10-1966		23c. NAME OF CEMETERY OR CREMATORY DORRANCE CEMETERY		23d. LOCATION (City or Town) (County) (State) DORRANCE PA			
24. FUNERAL DIRECTOR Leroy Webster				ADDRESS Princess Anne Md 21853		25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

34251

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CERTIFICATE OF DEATH

17997

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 09.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS Edgewood Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Levin Major		4. DATE OF DEATH Month Day Year December 23 19 66	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1908
9. AGE (In years lost birthday) yrs. 58		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Major		14. MOTHER'S MAIDEN NAME Nettie Boston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no -		16. SOCIAL SECURITY NO. 217-10-8510	
17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from December 23 1966 to December 23 1966 that (X) (we) last saw the deceased alive on Dec. 23 1966 , and that death occurred at 8:20 A.M. , from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Dec. 23, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland -21801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/66	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or Town) (County) (State) Cambridge Dor. Md.
24. FUNERAL DIRECTOR Julius C. Davis		25. REG'D BY REGISTRAR DEC 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0008

1548

18001

CERTIFICATE OF DEATH

17998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23.2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 8 4th St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Matthews		4. DATE OF DEATH Month Day Year December 21 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1895
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Schoolfield		14. MOTHER'S MAIDEN NAME Martha Hale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah Hughes Pocomoke, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days 4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/19/19 66 to 12/21/19 66 ; that (I) (we) last saw the deceased alive on 12/21/19 66 , and that death occurred at 4:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Oswald J. Burton		22b. DATE SIGNED 12/21/66	
22c. PHYSICIAN'S NAME (Type) Dr. Oswald J. Burton		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-28-66	23c. NAME OF CEMETERY OR CREMATORY St. James	23d. LOCATION (City or Town) (County) (State) Pocomoke Wor. Md.
24. FUNERAL DIRECTOR Samuel Savage New Church, Co.		25a. REC'D BY REGISTRAR DATE 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

12004

CERTIFICATE OF DEATH

12004

Wisconsin

Salisbury

Pennsylvania General Hospital

18002

CERTIFICATE OF DEATH

17999

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 19.2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Corrie L. McIntyre		4. DATE OF DEATH Month December Day 21 Year 1966		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1884		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Jones				14. MOTHER'S MAIDEN NAME Carolene Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Audrey Wolf Old Delmar Road Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) thrombotic cerebral hemorrhage DUE TO (b) Cerebral atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-20, 1966 , to 12-21, 1966 , that (I) (we) last saw the deceased alive on 12-21, 1966 , and that death occurred at 1:25 PM , from causes and on the date stated above.							
22a. SIGNATURE Robert D. White, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1966		23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) Md (State) Mt. Vernon; Somerset Co.	
24. FUNERAL DIRECTOR James A. Linn				ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR DEC 27 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12000

UNITED STATES

10000

Michigan

Sanitary

Sanitary General Hospital

Sanitary

Sanitary General Hospital

Sanitary General Hospital

Sanitary General Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18003

CERTIFICATE OF DEATH

18000

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN TB <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTER</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Main Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. McINTURFF</u>				4. DATE OF DEATH <u>December 24</u> 19 <u>66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19-1891</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED paper SUPERVISOR</u>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GABRIEL McINTURFF</u>				14. MOTHER'S MAIDEN NAME <u>MARY WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W.I.</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>DAMES QUARTER MRS ADDIE McINTURFF - MARYLAND.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 ____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 13</u> , 19 <u>66</u> , to <u>Dec 24</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>Dec 24</u> , 19 <u>66</u> , and that death occurred at <u>5:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>12/26/66</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEECHWOOD CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCESS ANNE SOM MD</u>	
24. FUNERAL DIRECTOR <u>Leroy Webster Princess Anne Md</u>				25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18000

STATE OF TEXAS

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General Land Office

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General Land Office

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18004

CERTIFICATE OF DEATH

18001

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN - lb ADM. IN 1 D 12/16/66	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Main & Bratten Sts.	
3. NAME OF DECEASED (Type or print) Emma First Middle Last (NMI) Miller		4. DATE OF DEATH DECEMBER 28 19 66 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1867
9. AGE (In years last birthday) 99 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk. Fissler		14. MOTHER'S MAIDEN NAME Barbara Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Sylvester Maxwell Miller, Jr. (Son) Box 95, Mardela Springs, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) and Generalized Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Renal Disease with Uremia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 1966 , to Dec 28, 1966 , that (I) (we) last saw the deceased alive on Dec 28, 1966 , and that death occurred at 10A M, from causes and on the date stated above.			
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED 12/28/66	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill, Jr.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 31, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City or Town) (County) (State) Howard County, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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Penicillin General Hospital

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 01-11-01 BY 60322 UCBAW/STP

18005

CERTIFICATE OF DEATH

18002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 64 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS RFD # 4 - Snow Hill Road	
3. NAME OF DECEASED (Type or print) First Preston NORRIS (M.) Middle Mitchell Last Mitchell		4. DATE OF DEATH Month December Day 1 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Timber	9. AGE (In years last birthday) 62 yrs.
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mitchell		14. MOTHER'S MAIDEN NAME Martha J. Coulbourne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-1922	
17. INFORMANT Mr. Preston E. Mitchell (Son) R.D. #4, Snow Hill Rd., Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) head and Carcinoma of/body of pancreas with wide-spread metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from 9/28 , 19 66 , to 12/1 , 19 66 , that the (we) last saw the deceased alive on 12/1 , 19 66 , and that death occurred at 1 P. M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED 12/1/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 3, 1966	23c. NAME OF CEMETERY OR CREMATORY Mitchell Family Cemetery	23d. LOCATION (City or Town) (County) (State) Wicomico County, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 5 1966 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California Ventura c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxnard 43.3					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						c. LENGTH OF STAY IN 1b 3 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 708 S. Park Dr.,						d. STREET ADDRESS 420 Douglas Ave.,					
3. NAME OF DECEASED (Type or print) JANE KYLE NEEDHAM						4. DATE OF DEATH 12 19 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1897		9. AGE (In years last birthday) 69 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert McClintock						14. MOTHER'S MAIDEN NAME Frances Lawrence					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Henry P. Needham. see sec 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension C.V. Disease (a), stating the underlying cause last. DUE TO (c) Stroke INTERVAL BETWEEN ONSET AND DEATH 1 year											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Earl L. Royer M.D. DATE SIGNED 12-19-1966 EXAMINER'S NAME (Type) Dr. Earl L. Royer Salisbury, Md. Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-21-1966		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Va.			
23. FUNERAL DIRECTOR Hill Funeral Home ADDRESS Salisbury, Maryland						24a. REC'D BY REGISTRAR DEC 23 1966		24b. REGISTRAR'S SIGNATURE Charles Judge			

Norman T. Baker

[Handwritten signature]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18004

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>116 Fooks Street</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>EDNA</u> Last <u>NOCK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u>12</u> Min.	11. IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Parker, William John</u>		14. MOTHER'S MAIDEN NAME <u>Sally Ann ---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Mr. Ralph F. Nock (Son)</u> <u>Baysinger Trailer Court, Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>904.0</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Fx Rt. Femur</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12-13</u> p.m. <u>1966</u>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Maryland</u>		22. DATE SIGNED <u>Dec. 20 / 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 22 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	

1903

1903

John
Gibbs

John Gibbs
7-11-03

John Gibbs
7-11-03

John Gibbs
7-11-03

7-11-03

John Gibbs
7-11-03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18008
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 500 Winder Street		d. STREET ADDRESS 500 Winder Street	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLIE (NMI) PHILLIPS		4. DATE OF DEATH December 5 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State, or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Phillips		14. MOTHER'S MAIDEN NAME Estelle Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Clarence E. Phillips (Brother)		Address 500 Winder Street, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO (b) Coronary arteriosclerosis DUE TO (c) Cardiovascular hypertensive disease		INTERVAL BETWEEN ONSET AND DEATH 3 min 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular hypertensive disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 , to Dec 5, 1966 , that (I) (we) last saw the deceased alive on Dec 1, 1966 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Dec. 6 / 1966	
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Sohler		22d. ADDRESS 303 East Street, Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1966	
23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 8 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

13003

18803

Government of the United States
Department of the Interior

Chief of the Bureau of Land Management

For 1st of
M. S. M.

22 Dec 88

6

18009

CERTIFICATE OF DEATH

18006

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague 83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 401 Willow Street	
3. NAME OF DECEASED (Type or print) First LULA Middle Priscilla Last Phipps		4. DATE OF DEATH Month DECEMBER Day 28 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Schoolteacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching School	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME G. Ruben Phipps		14. MOTHER'S MAIDEN NAME Mary Richardson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice Kambarn, Chincoteague, Virginia		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 175.0 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO (b) CARCINOMA - OVARY DUE TO (c) CAUSE OF DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 mos -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20 Nov , 19 66 , to Dec 27 , 19 66 , that (I) (we) last saw the deceased alive on 27 Dec , 19 66 , and that death occurred at 4:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Jay Lewis M.D.		22b. DATE SIGNED 28 Dec 66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Mechanics Cemetery	23d. LOCATION (City or town) (County) (State) Chincoteague, Virginia
24. FUNERAL DIRECTOR Salzer Funeral Home, Chincoteague, Virginia		25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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29921

2003

1990:138

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G384 1/9/67 mh

CERTIFICATE OF DEATH

18010

18007

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 10 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 801 Camden Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First CASPER		Middle Pierce		Last Pierce		4. DATE OF DEATH Month December	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-1893		9. AGE (In years last birthday) yrs. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (County & State, or foreign country) Delaware, St. George's		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 Year Months Days Hours Min.	
13. FATHER'S NAME Edward C. Pierce				14. MOTHER'S MAIDEN NAME Mary Watson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Ruth S. Pierce, see sec.2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage DUE TO (b) Peptic ulcer DUE TO (c) Peptic ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Left hemiplegia - Incomplete lateral hernia Polycythemia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 1958 to 12-19 , 19 66 , that (I) (we) last saw the deceased alive on 12-19 , 19 66 , and that death occurred at 4:01 P. M, from causes and on the date stated above.									
22a. SIGNATURE Philip A. Insley				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-19-1966			
22c. PHYSICIAN'S NAME (Type) Philip A. Insley				22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Maryland			
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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18010

Alcoholic

Delirium

Pennsylvania General Hospital

William

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Alcoholic

Delirium

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 23b, 23c, 23d Film G384 1/19/67 mh

CERTIFICATE OF DEATH

18011		18008	
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRUITLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES HENRY POWELL		4. DATE OF DEATH DECEMBER 14 19 66	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		11. BIRTHPLACE (County & State, or foreign country) SNOW HILL	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Powell	
14. MOTHER'S MAIDEN NAME Sallie Ames		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Lula Powell - Fruitland Md. Box 574	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous aspiration of vomitus 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH seconds	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 55 to Dec 14 , 19 66 , that (I) (we) last saw the deceased alive on Dec 13 , 19 66 , and that death occurred at 3:30 M, from causes and on the date stated above.			
22a. SIGNATURE Robert M. McKus		22b. DATE SIGNED 19 Dec 66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-16-66	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City or Town) (County) (State) Smithfield Berlin, Md.	
24. FUNERAL DIRECTOR Louella B. Jolly		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 23 1966	

18002

Wichita

Salisbury

Pennington's General Hospital

18002

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death		Place of death	
John A. Smith		Male		45		Jan 15 1900		Wichita, Kan.	
Cause of death		Disease		Symptoms		Treatment		Remarks	
Pneumonia		Pneumonia		Cough, fever, etc.		Medicine, etc.		Recovered	
Signature of physician		Signature of witness		Signature of undertaker		Signature of registrar		Signature of coroner	
J. A. Smith		J. B. Jones		J. C. Brown		J. D. Green		J. E. White	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18012

CERTIFICATE OF DEATH

18009

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23 2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girdletree d. STREET ADDRESS RFD # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa MARY Redden		4. DATE OF DEATH Month Day Year December 13 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Girdletree, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward F. Hancock		14. MOTHER'S MAIDEN NAME Mary Grace Pruitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 230525117	
17. INFORMANT Merrill F. Redden, Girdletree, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Shut down DUE TO (b) Diabetic Acidosis DUE TO (c) Septicemia due to E. Coli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 days 14 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 12 1966 , to Dec 12 1966 that (I) (we) lost saw the deceased alive on Dec 12 1966 and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE David Rafat		22b. DATE SIGNED 12-13-66	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/15/66	23c. NAME OF CEMETERY OR CREMATORY Springhill Methodist	23d. LOCATION (City or Town) (County) (State) Girdletree, Maryland
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR Snow Hill, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 16 1966	

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18012

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18013

CERTIFICATE OF DEATH

18010

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 23.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tocomoke, md d. STREET ADDRESS 23.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Addie Middle Reid Last Reid		4. DATE OF DEATH Month December Day 28 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4, 1921
9. AGE (In years last birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
11. BIRTHPLACE (County & State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Foster		14. MOTHER'S MAIDEN NAME Mary P.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 224-40-9158	
17. INFORMANT George Reid		Address Tocomoke, md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Medical Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/27, 1966 to 12/28, 1966 , that (I) (we) last saw the deceased alive on 12/28, 1966 , and that death occurred at 12/28, 1966 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 12/28/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-2-67	23c. NAME OF CEMETERY OR CREMATORY Linsley Chapel	23d. LOCATION (City or Town) (County) (State) Tocomoke md.
24. REGISTRAR Samuel Savage - New Church, Va.		25a. REC'D BY REGISTRAR JAN 3 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18010

RECEIVED BY DEATH

18013

Alcoholic

Gallop

Fennell General Hospital

18014

CERTIFICATE OF DEATH

18011

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle - Last Reid		4. DATE OF DEATH Month December Day 9 Year 1966	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1889
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Reid		14. MOTHER'S MAIDEN NAME Addie Swann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. 218-16-8692	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shamtion DUE TO (b) Multivitamin Deficiency DUE TO (c) Pulmonary Tuberculosis, Far Advanced, Active		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 6 mos. Oct. 1966	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Nov. 9 , 1966, to Dec. 9 , 1966, that (we) saw the deceased alive on Dec. 9 , 1966, and that death occurred 11:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Rufus S. Gardner, Jr.		22b. DATE SIGNED 12/9/66	22c. PHYSICIAN'S NAME (Type) Rufus S. Gardner, Jr., M.D.
22d. ADDRESS Salisbury, Maryland		22e. REC'D BY REGISTRAR Charles Judge	
22f. REGISTRAR'S SIGNATURE Charles Judge		22g. DATE DEC 13 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12 12 66	23c. NAME OF CEMETERY OR CREMATORY Unalomed Rd
23d. LOCATION (City or Town) Belt		(County) (State)	
24. FUNERAL DIRECTOR Brakes M. West		25. ADDRESS	

11081

RECEIVED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
18015					18012					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Wicomico MARYLAND					a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico County Nursing Home					d. STREET ADDRESS 802 E. William Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WALTER			Middle LEE		Last RUARK		4. DATE OF DEATH Month December		Day 9	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1896		9. AGE (In years last birthday) 70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lee Ruark					14. MOTHER'S MAIDEN NAME Jannie Lowe					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Pauline L. Ruark (wife) 802 E. William St., Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.										
22a. SIGNATURE <i>Richard E. Hughes</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED Dec. 12 / 1966		
22c. PHYSICIAN'S NAME (Type) Dr. Richard Hughes					22d. ADDRESS Medical Center, Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Walston (Bethel Cemetery)		23d. LOCATION (City, town or county) (State) Wicomico County, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE DEC 14 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

18013

RECEIVED

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FOR STATE
HEALTH DEPT.

18016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18013

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital D.O.A.</u>				d. STREET ADDRESS <u>R.D. #1 (Shad Point)</u>			
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>WILLIAM</u> Last <u>SAHLER III</u>				4. DATE OF DEATH <u>December 25</u> 19 <u>66</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1947</u>		9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee - Mach. Operator - Nylon Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick W. Sahler, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Josephine Colvin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-44-1034</u>		17. INFORMANT (Address) <u>Mrs. Nora Lynn Sahler (wife)</u> <u>R.D. #1, Shad Point, Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>8304</u> IMMEDIATE CAUSE (a) <u>Crushed Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while shovelling snow</u>					
20c. TIME OF INJURY Month, Day, Year <u>8</u> <u>12-25</u> 19 <u>66</u> Hour <u>a.m.</u> <u>p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Dec. 27 / 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1861

1861

General Check

1861

80 11-22 11
I have thought of you
and will be able to see

Yours truly
J. R. R.

55

18017

CERTIFICATE OF DEATH

18014

1. PLACE OF BIRTH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		232			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 801 WALNUT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First AGNES		Middle Annie		Last SHAW			
4. DATE OF DEATH Month December		Day 23		Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-1897			
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 69		IF UNDER 24 HRS. Days 69		Hours 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Somerset County Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Parks				14. MOTHER'S MAIDEN NAME Laura Miles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-28-2590		17. INFORMANT Address Mrs Harry Ward, Delmar, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from March , 19 66 , to Dec. 23, 1966 , that (I) (we) last saw the deceased alive on Dec. 16 1966 , and that death occurred at 7:30 P.M. from causes and on the date stated above									
22a. SIGNATURE David J. Gilmore				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-23-66			
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE				22d. ADDRESS Medical Center, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-26-1966		23c. NAME OF CEMETERY Presbyterian		23d. LOCATION (City or Town) (County) (State) Pocomoke Worcester Md.			
24. FUNERAL DIRECTOR Robert H. Watson				ADDRESS Pocomoke, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

18014

18014

Wisconsin

Jefferson

Peninsula General Hospital

18018

CERTIFICATE OF DEATH

18015

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Mt. Hermon Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Annie BELLE Shockley			4. DATE OF DEATH Month Day Year December 9 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 5 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Hammond			14. MOTHER'S MAIDEN NAME Sally Lank		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. E. Lester Shockley (Son) R.D. #1, Parsonsburg, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH Two weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9 , 19 66 , to 12-9 , 19 66 , that (I) (we) last saw the deceased alive on 12-9 , 19 66 , and that death occurred at 9:57 M, from causes and on the date stated above.					
22a. SIGNATURE Wilbur R. Ellis Jr.			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-9-66	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R. Ellis, Jr.			22d. ADDRESS Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DATE DEC 12 1966		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18012

CERTIFICATE OF DEATH

18012

Wisconsin

Salisbury

Peninsula General Hospital

Handwritten signature

18019

CERTIFICATE OF DEATH

18016

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 23.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Ocean City d. STREET ADDRESS Elm St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LARRY JAMES SHOCKLEY First Middle Last 4. DATE OF DEATH December 23 1966 Month Day Year		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 6, 1886 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY HOTEL 11. BIRTHPLACE (County & State, or foreign country) SNOW HILL MD 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELWATH SHOCKLEY 14. MOTHER'S MAIDEN NAME MAGGIE TYRE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 212-16-7288 17. INFORMANT MRS IRA ALLEN, DEGAN CITY MD Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 203X Multiple Myeloma IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 64 , to 12-23 , 19 66 , that (I) (we) last saw the deceased alive on 12-23 , 19 66 , and that death occurred at 5:30 AM, from causes and on the date stated above.			
22a. SIGNATURE John S. Bulkeley 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 12-24-66 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/18/66	
23c. NAME OF CEMETERY OR CREMATORY BETHEL		23d. LOCATION (City or Town) (County) (State) BETHEL WIC MD	
24. FUNERAL DIRECTOR Anna A. Burboy ADDRESS		25. REC'D BY REGISTRAR DEC 28 1966 DATE	
		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

31981

21082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18020

CERTIFICATE OF DEATH

18017

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) d. STREET ADDRESS Rt. 5 Bowman Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Mae Short		4. DATE OF DEATH Month Day Year December 25 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1888
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min. 12 24 00 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Cluff		14. MOTHER'S MAIDEN NAME Mary Ann Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Stanley Bradley		Address Route 5 Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 451X IMMEDIATE CAUSE (a) pneumonia, bilateral; post-operative DUE TO (b) resection abdominal aortic aneurysm DUE TO (c) 12/6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 day - 9 days -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypothyroidism -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 12-25 19 66 , and that death occurred at 3:30 M, from causes and on the date stated above.			
22a. SIGNATURE W. P. Sadler NEVINS W. Todd Jr.		22b. DATE SIGNED 12-25-66	
22c. PHYSICIAN'S NAME (Type) NEVINS W. Todd Jr.		22d. ADDRESS Medical Center - Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-1966	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Thomas F. Wallace		ADDRESS Salisbury, Md.	
25a. REC'D. BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE James F. Jones	

1901

UNITED STATES

1901

Wichita

Salisbury

Central General Hospital

1901

FOR STATE HEALTH DEPT.

18021

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18018

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Delmar</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 46.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>		d. STREET ADDRESS <u>8 Hitchens St.</u>	
3. NAME OF DECEASED (Type or print) <u>Willis Smiley</u>		4. DATE OF DEATH <u>12-14-66</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years) <u>51</u> <u>24</u> <u>15</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>Cyrus Smiley</u>		14. MOTHER'S MAIDEN NAME <u>Ada Hotten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>21-7-148636</u>	
17. INFORMANT <u>Chris Smiley</u> Address <u>Wilmington, Del.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>409 Camden Ave. Salisbury, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>December 16, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Sharptown, Md.</u>
24. FUNERAL DIRECTOR <u>West Funeral Home, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1801

1801

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1801

1801

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18022

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18019

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>605 Hill St.</u>	
3. NAME OF DECEASED (Type or print) First <u>CLEVELAND</u> Middle <u>SOLOMAN</u> Last <u>JR.</u>		4. DATE OF DEATH Month <u>12</u> -Day <u>25</u> -Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cleveland Solomon SR.</u>		14. MOTHER'S MAIDEN NAME <u>Carry Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Cleveland Solomon</u>		Address <u>Philadelphia Pa.</u> <u>621 N. 12 St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>981X</u> IMMEDIATE CAUSE (a) <u>Gunshot wound of chest (heart)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot during argument</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30</u> <u>12-25-66</u> Hour <u>5:30</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		22. DATE SIGNED <u>December 27, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/6/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Nebo</u>		23d. LOCATION (City or Town) (County) (State) <u>Columbia</u> <u>Del.</u>	
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 6 1967</u>	
ADDRESS <u>Salisbury Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

18018

18018

Letting you know
that I have received
your letter of the 10th

Yours truly
J. B. L.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

18023

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G384 12/30/66 mb

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18020

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville 46-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS Rt. 1, Box 299	
3. NAME OF DECEASED (Type or print) CAROLINE STEWARD		4. DATE OF DEATH Month 12-3-66 Day 19 Year 19	
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11. BIRTHPLACE (State or foreign country) DELAWARE	
13. FATHER'S NAME Wm. HENRY STEWARD		14. MOTHER'S MAIDEN NAME MADGE MAE HOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT LORENZO GARRISON		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Multiple fractures DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto that hit tree.	
20c. TIME OF INJURY Month, Day, Year 1:30 PM 12-3-66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) highway - Rt. 113, Bishop, Worcester, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED December 3, 1966	
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-7-66	
23c. NAME OF CEMETERY OR CREMATORY OLD FIELD CEMETERY		23d. LOCATION (City or Town) (County) (State) MILLSBORO, SUSSEX, DEL.	
24. FUNERAL DIRECTOR WATSON + GRAY-MELSON		25a. REC'D BY REGISTRAR DEC 21 1966	
Address Dodd-Carey Funeral Home, Georgetown, Del. DEL.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1908

1908

W. H. H. H.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
18024				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				18021			
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague 83.3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital						d. STREET ADDRESS 100 Fillmore St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE WILBURT TAYLOR						4. DATE OF DEATH Month Day Year 12-3-66 19					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-05		9. AGE (In years lost birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Fillmore Taylor						14. MOTHER'S MAIDEN NAME Annie Watson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 226-14-6799		17. INFORMANT Address Alma Taylor, Chincoteague, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer, M.D.						22. DATE SIGNED December 5, 1966					
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-6-1966		23c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		23d. LOCATION (City or Town) (County) (State) Oak Hall, Virginia			
24. FUNERAL DIRECTOR ADDRESS Salyer Funeral Home, Chincoteague, Va.						25a. REC'D BY REGISTRAR DATE DEC 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

19081

19081

John R. [unclear]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18025

CERTIFICATE OF DEATH

18022

1. PLACE OF DEATH a. COUNTY Wicomico				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB 9 Days				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Wicomico				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin				d. STREET ADDRESS 22.1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital																4. DATE OF DEATH Month December Day 11 Year 1966																							
3. NAME OF DECEASED (Type or print) George Washington Timmons				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/9/1909				9. AGE (In years last birthday) 57 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman Oyster Toner				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George W. Timmons								14. MOTHER'S MAIDEN NAME Alice C. Hayward								15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No								16. SOCIAL SECURITY NO. 216-18-2178								17. INFORMANT Ruby Williams, White Haven, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Basilar Art. Brain DUE TO (b) ASCVD. DUE TO (c) ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from 12-01-66 , 19 to 12-11 , 1966, that (I) (we) last saw the deceased alive on 12-11 , 1966, and that death occurred at 4:35 AM , from causes and on the date stated above.																22a. SIGNATURE Joseph C. Fitzgerald																22b. DATE SIGNED 12-11-66							
22c. PHYSICIAN'S NAME (Type) Joseph C. Fitzgerald								22d. ADDRESS 5-1156-y, Md.																															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/13/66				23c. NAME OF CEMETERY OR CREMATORY Bivolve Cem.				23d. LOCATION (City or Town) (County) (State) Bivolve, Md.				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge																			
24. FUNERAL DIRECTOR Charles Judge																25c. ADDRESS Bivolve, Md.																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18035

CERTIFICATE OF DEATH

18035

Alameda

California

San Francisco General Hospital

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS AND THE PHYSICIAN IN CHARGE OF THE HOSPITAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

18026

CERTIFICATE OF DEATH

18023

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 46.3		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE		b. COUNTY SUSSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRANKFORD		d. STREET ADDRESS RURAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLAYTON		First		Middle		Last TOWNSEND		4. DATE OF DEATH Month DECEMBER		Day 22		Year 1966					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1907		9. AGE (In years last birthday) 59 Yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE E. TOWNSEND		14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 222-10-1907		17. INFORMANT STELLA L. TOWNSEND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) pulmonary embolism DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Aortic stenosis & insufficiency - RHD.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24. Chronic & upper infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 12-29-66		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 12-18, 1966 , to 12-22, 1966 , that (1) (we) last saw the deceased alive on 12-22, 1966 , and that death occurred at 3:47 M, from causes and on the date stated above.		22a. SIGNATURE Hevin W. Todd		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Hevin W. Todd		22d. ADDRESS MEDICAL CENTER - SALISBURY MD		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-25-66		23c. NAME OF CEMETERY, OR CREMATORY ST. GEORGES Cem.		23d. LOCATION (City or Town) (County) (State) CLARKSVILLE, SUSSEX, DELA.	
24. FUNERAL DIRECTOR A. Douglas Nelson, Frankford, Del.		25a. REC'D BY REGISTRAR DATE 10 1500		25b. REGISTRAR'S SIGNATURE Charles J. J...													

MEDICAL CERTIFICATION

18021

CONTRACT OF DEATH

18021

Wicomico

Salisbury

Peninsula General Hospital

Contract

What

COPIES OF THIS CONTRACT
SHALL BE FURNISHED TO THE
LOCAL HEALTH DEPARTMENT
AND TO THE STATE DEPARTMENT
OF HEALTH AND HUMAN
RESOURCES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18027

CERTIFICATE OF DEATH

18024

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS R D # 2		
3. NAME OF DECEASED (Type or print) HAZEL H. TOWNSEND			4. DATE OF DEATH DECEMBER 5 1966		
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-14-93		9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester Md.	
12. CITIZEN OF WHAT COUNTRY? U S		13. FATHER'S NAME Isaac Holland		14. MOTHER'S MAIDEN NAME Annie Quillen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-38-1581		17. INFORMANT Flossie Thomas Address Berlin, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Carcinoma of colon, metastatic to bladder & liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 66 , to 12/5 , 19 66 , that (I) (we) last saw the deceased alive on 12/5 , 19 66 , and that death occurred at 3 P. M, from causes and on the date stated above.					
22a. SIGNATURE William P. Sadler M.D.		22b. DATE SIGNED 12/7/66		22c. PHYSICIAN'S NAME (Type) William P. Sadler	
22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-8-66		23c. NAME OF CEMETERY OR CREMATORY Buckingham	
23d. LOCATION (City or Town) (County) (State) Berlin Wor. Md.					
24. FUNERAL DIRECTOR William H. H. Georgetown		ADDRESS Georgetown		25a. REC'D BY REGISTRAR DEC 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

18054

UNITED STATES OF AMERICA

18054

Witnessed

Salisbury

Tennant's General Hospital

1111

NOV 1910

THE STATE OF NEW YORK

IN SENATE

JAN 1911

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

IN

RESPONSE

TO A

RESOLUTION

PASSED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
18025											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAGGIE P. Townsends</u>						4. DATE OF DEATH Month Day Year <u>DEC. 27 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1868</u>		9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEWARK MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>GEORGE L.R. POWELL</u>						14. MOTHER'S MAIDEN NAME <u>—</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>217-54-6023</u>		17. INFORMANT <u>Mr. Carlton Powell Berlin MD</u> Address <u>Berlin MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>286.5 Exposure to cold</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>malnutrition - chronic</u>										years <u>—</u>	
(c) <u>—</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large decubitus ulcer R hip.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 26 1966</u> , to <u>Dec 27 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 26 1966</u> and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>David Rafat</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>						22d. ADDRESS <u>Snow Hill, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>12/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>			23d. LOCATION (City, town or county) (State) <u>Berlin MD</u>			
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin MD</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>JAN 4 1967</u>											

2512

1562



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

18023

CERTIFICATE OF DEATH

18026

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Adm. in 1b Dec. 20, 1966 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS R.D. #1 (Camden Ave. Extd.) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PRATT		First COOPER		Last TOWNSEND		4. DATE OF DEATH Month December Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1922	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 0 Days 2	IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Soft Drink Co.		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warden Cooper Townsend				14. MOTHER'S MAIDEN NAME Louise LeCates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) War II		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris Lee (White) Townsend (wife) Address R.D. #1, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 Cirrhosis of liver DUE TO (b) chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/a					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 , 19 66 , to 12/26 , 19 66 , that (I) (we) last saw the deceased alive on 12/26 19 66 , and that death occurred at 5:23 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Earl Beardsley				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 27/1966	
22c. PHYSICIAN'S NAME (Type) Dr. Earl Beardsley				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 29 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18030

CERTIFICATE OF DEATH

18027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN Tb since 6/21/66		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 03.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital				d. STREET ADDRESS 25 Sanford Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Wesley Last Trader				4. DATE OF DEATH Month December Day 27 Year 1966			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1877		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer - retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Trader				14. MOTHER'S MAIDEN NAME Mary Ennis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-01-4569		17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 002.1 IMMEDIATE CAUSE (a) Senile Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from June 21, 1966 , to Dec. 27, 1966 that he (we) last saw the deceased alive on Dec. 27, 1966 , and that death occurred at 6:45 p.m. , from causes and on the date stated above.							
22a. SIGNATURE E. P. Ritchings				M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 28, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.				22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland- 21801			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Charles W. Samuel				25a. REC'D BY REGISTRAR DEC 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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(M)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

18031

18028

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT 3, Pocomoke		23.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Griffin		First Middle Last -		4. DATE OF DEATH December 22		19 66	
5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 7, 1903	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		11. BIRTHPLACE (County & State, or foreign country) Pocomoke, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William TRUITT				14. MOTHER'S MAIDEN NAME Sally MOORE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS IDA TRUITT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) A.S.C.V.D. DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Years Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 66 , to 12-22 , 19 66 , that (I) (we) last saw the deceased alive on 12-22 , 19 66 , and that death occurred at 6:30 M, from causes and on the date stated above.							
22a. SIGNATURE Joseph C. Fitzgerald				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-22-66	
22c. PHYSICIAN'S NAME (Type) JOSEPH C. FITZGERALD				22d. ADDRESS Salisbury, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/24/1966		23c. NAME OF CEMETERY OR CREMATORY BAPTIST		23d. LOCATION (City or Town) (County) (State) GIRDLETREE MD.	
24. FUNERAL DIRECTOR Donald C. Snow				ADDRESS Snow Hill, MD.		25a. REC'D BY REGISTRAR DEC 27 1966	
						25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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18032

CERTIFICATE OF DEATH

18029

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 22.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital DOA		d. STREET ADDRESS Cromwell Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle Earl Last Tull		4. DATE OF DEATH Month December Day 21 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Appliance	9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months 1 Days 29 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Earl Tull		14. MOTHER'S MAIDEN NAME Nellie Lawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Ruth B. Tull (Wife) Cromwell Road, Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary DUE TO 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 27 hrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/19 , 19 64 , to 12/21 , 19 66 that (I) (we) last saw the deceased alive on 12/20 19 66 , and that death occurred at 3 PM , from causes and on the date stated above.			
22a. SIGNATURE W. B. Smith		22b. DATE SIGNED 12/21/66	22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith
22d. ADDRESS Salisbury, Maryland		22e. REC'D BY REGISTRAR DEC 21 1966	
22f. REGISTRAR'S SIGNATURE Charles Judge		22g. REGISTRAR'S NAME HOLLOWAY & COMPANY, SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunny Ridge Cemetery
23d. LOCATION (City or Town) (County) (State) Crisfield, Maryland		23e. REGISTRAR'S NAME HOLLOWAY & COMPANY, SALISBURY, MARYLAND	

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1883

RECEIPT OF DEBIT

1883

Wichita

Collection

For the year ending 1883

Wichita

1883

Wichita

1883

Wichita

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18033

CERTIFICATE OF DEATH

18030

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 19.2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS MAIN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE C. WALTERS		4. DATE OF DEATH Month Day Year DECEMBER 13 1966		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 7-1880		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BARBER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN		14. MOTHER'S MARDEN NAME SARAH FISHER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT CLYDE WALTERS		Address MD DEAL ISLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO (b) Pulm. emphysema + fibrosis DUE TO (c) Obstructive airwaysdis		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-10 , 19 66 , to 12-13 , 19 66 , that (I) (we) last saw the deceased alive on 12-13 , 19 66 , and that death occurred at 8:27 AM , from causes and on the date stated above.							
22a. SIGNATURE Joseph C. Fitzgerald				22b. DATE SIGNED 12/13/66		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/16/66		23c. NAME OF CEMETERY OR CREMATORY ST JOHN'S CEMETERY		23d. LOCATION (City or Town) (County) (State) DEAL ISLAND MD	
24. FUNERAL DIRECTOR Kerry Webster		ADDRESS Princess Anne		25a. REC'D BY REGISTRAR DEC 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12024

18034

CERTIFICATE OF DEATH

18031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium		d. STREET ADDRESS Antioch Ave.	
3. NAME OF DECEASED (Type or print) Eva Webster		4. DATE OF DEATH Month December Day 10 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 93
11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Young		14. MOTHER'S MAIDEN NAME Alice J. Absolum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel Wilson, Princess Anne, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3344 IMMEDIATE CAUSE (a) Shoke DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/9/1966 to 12/10/1966 , that (I) (we) lost saw the deceased alive on 12/9/1966 , and that death occurred at 12/10/1966 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/13/1966	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	23d. LOCATION (City or Town) (County) (State) Mt. Vernon; Somerset Co. Md.
24. FUNERAL DIRECTOR James Huxman		25a. REC'D BY REGISTRAR DATE DEC 16 1966	
ADDRESS Princess Anne, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

18631

2621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
18035					18032						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Wicomico</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>						
c. LENGTH OF STAY IN 1b Adm. in 1-D <u>11/5/66</u>					d. STREET ADDRESS <u>Culver Street</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>GLEAMON</u>		<u>EARL</u>		<u>WEBSTER</u>		Month <u>December</u> Day <u>16</u> Year <u>19 66</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Deal Island, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>David Webster</u>						14. MOTHER'S MAIDEN NAME <u>Emma Graham</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-10-2703</u>		17. INFORMANT <u>Mrs. Della F. Webster (wife)</u> <u>Culver Street, Hebron, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> <u>metastatic C.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>C.A. of Stomach</u> DUE TO (c) <u>2 years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2-11-61</u> , 19 <u>61</u> , to <u>12-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> , 19 <u>66</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Earl E. Royer</u>						22b. DATE SIGNED <u>Dec. 7 / 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Earl E. Royer</u>						22d. ADDRESS <u>409 Camden Avenue, Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Dec. 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hebron, Maryland</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 22 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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18093

A.C. started
land? p. A.C.

with
myself

12-11-11

12-11-11

12

John King

CERTIFICATE OF DEATH

18036

18033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 yrs. 7mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville, R.F.D.#1		17.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Deer's Head State Hospital	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elwood Middle Jacob Last Weller		4. DATE OF DEATH Month Dec. Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Weller		14. MOTHER'S MAIDEN NAME Addie Wooleyhan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 221-16-6742	
17. INFORMANT Mrs. Ethel M. Weller,		Address R.F.D.#1 Sudlersville, Md. 21668	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Tracheobronchitis & bronchopneumonia DUE TO (c) 3u		INTERVAL BETWEEN ONSET AND DEATH 10u	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 2, 1960 to Dec. 2, 1966 , that (I) (we) lost the deceased alive on Dec. 2, 1966 , and that death occurred at 1:25 PM , from causes on and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M.D.		22b. DATE SIGNED Dec. 3, 1966	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		22d. ADDRESS Deer's Head State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 6, 1966	
23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A.Co; Md.	
24. FUNERAL DIRECTOR Edward Fellows.		25a. REC'D BY REGISTRAR DATE DEC 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

3623

18081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH						
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
18037			CERTIFICATE OF DEATH			
1			18034			
1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			b. COUNTY Dorchester			
c. LENGTH OF STAY IN 1b 15 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS --			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ida Virginia Hastings Wheatley			4. DATE OF DEATH Month December Day 21 Year 1966			
5. SEX Female			6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 6, 1897			
9. AGE (In years last birthday) 69 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (County & State, or foreign country) Dorchester, Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles W. Hastings			14. MOTHER'S MAIDEN NAME Ida Virginia Mowbray			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 220-16-9458			
17. INFORMANT Mrs. Francis Leh, Hurlock, Maryland			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) - pulmonary embolus - DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Transfusion Hctus Hctus Repair 12-9-66						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 66 , to 12-21 , 19 66 , that (I) (we) last saw the deceased alive on 12-19 , 19 66 , and that death occurred at 10:10 A.M. , from causes and on the date stated above.						
22a. SIGNATURE NEVINS W. TODD			22b. DATE SIGNED 12-21-66			
22c. PHYSICIAN'S NAME (Type) NEVINS W. TODD			22d. ADDRESS MEDICAL CENTER - SALISBURY MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 23, 1966			
23c. NAME OF CEMETERY OR CREMATORY East New Market			23d. LOCATION (City or Town) (County) (State) East New Market, Dorc., Md.			
24. FUNERAL DIRECTOR Franklin Funeral Home			ADDRESS Federalsburg, Md.			
25a. REC'D BY REGISTRAR DEC 27 1966			25b. REGISTRAR'S SIGNATURE Charles Judge			

10083

Wisconsin

Bellevue

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

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Bellevue General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1-66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G384 12/27/66 mh

18038

CERTIFICATE OF DEATH

18035

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN Tb 19.2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion d. STREET ADDRESS 19.2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah B. Whittington First Middle Last 4. DATE OF DEATH December 20 19 66 Month Day Year		5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH May 13, 1936 9. AGE (In years last birthday) 30 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Lovey K. Kinkade 11. BIRTHPLACE (County & State, or foreign country) Pocomoke Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Turner 14. MOTHER'S MAIDEN NAME Lovey King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. 16. SOCIAL SECURITY NO. 214-34-5712 17. INFORMANT Brantley Whittington, Marion Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE INTRAPERITONEAL DUE TO (b) PERITONITIS - GENERALIZED DUE TO (c) ABSCESS TUBO-OVARIAN - RT INTERVAL BETWEEN ONSET AND DEATH 40 HRS 13 DAYS 13 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/8 , 1966, to 12/19 , 1966, that (I) (we) last saw the deceased alive on 12/19 , 1966, and that death occurred at 3:25 PM, from causes and on the date stated above.			
22a. SIGNATURE John M. Bloxom III 22c. PHYSICIAN'S NAME (Type) JOHN M. BLOXOM		22b. DATE SIGNED DEC 23 1966 22d. ADDRESS MEDICAL CENTER, SALISBURY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/22/66 23c. NAME OF CEMETERY OR CREMATORY Christ M.E. 23d. LOCATION (City or Town) (County) (State) Pocomoke City Worcester		24. FUNERAL DIRECTOR Charles H. Ward, Marion Sta, Md. 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DEC 23 1966	

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Peninsula General Hospital

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
18039					18036				
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS 411 Mount Street				
3. NAME OF DECEASED (Type or print) First Middle Last MILLARD BYRAN WILLIAMS					4. DATE OF DEATH Month Day Year December 2 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1899		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George H. Williams					14. MOTHER'S MAIDEN NAME Irene Fields				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-10-7695		17. INFORMANT Mrs. Nettie May Williams (Wife) 411 Mount Street, Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Generalized Carcinomatosis (b) Carcinoma of Pancreas (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3-6 mos 1-2 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11.18, 1966, to 12.2, 1966, that (I) (we) last saw the deceased alive on 12.2, 1966, and that death occurred at 8:55 AM, from the causes and on the date stated above.									
22a. SIGNATURE H. Briele					22b. DATE SIGNED Dec. 2, 1966				
22c. PHYSICIAN'S NAME (Type) H. Briele					22d. ADDRESS Medical Center Salisbury, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		23d. LOCATION (City, town or county) (State) Wicomico County, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DEC 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

18036

DEPARTMENT OF HEALTH

18036

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18040

CERTIFICATE OF DEATH

18037

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		22.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS R.F.D.2 Spring Hill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Suter				4. DATE OF DEATH Month DECEMBER Day 14 Year 1966			
5. SEX MALE	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1901	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bedford Williamson				14. MOTHER'S MAIDEN NAME Della ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 265-03-8667-A		17. INFORMANT Helen Williamson Salisbury Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Second Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Right Hilal Bronchogenic Carcinoma (b) 3 1/2 months (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1966 to Dec. 14, 1966 that (I) (we) lost saw the deceased alive on Dec. 13, 1966 and that death occurred at 8:30 M, from causes and on the date stated above.							
22a. SIGNATURE G. Herbert Senterly		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/17/66			
22c. PHYSICIAN'S NAME (Type) G. Herbert Senterly MD		22d. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/1966		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or town) (County) (State) Hebron Md.	
24. FUNERAL DIRECTOR Clinton F. Stewart		ADDRESS Salisbury Md		25a. REC'D BY REGISTRAR DEC 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18087

18087

Wisconsin

Salisbury

Peninsula General Hospital